CAP/DA Services - NEW Request

* = Required

Request Date *

Beneficiary Demographics		
Beneficiary's First Name		
Last Name		
Beneficiary has Medicaid? *	• Yes • Pending	• Not Applied • No
Medicaid MID		
Social Security Number		
Medicare ID		
Date of Birth		Age
Gender		
County		
Primary language		
Beneficiary Address		
Address 1		
Address 2		
City		
State	Zip	
Phone		
Receiving Protective Services? *	• Yes / No	
Legal Guardian Details		
Legal guardian in place? *	• Yes / No	
Guardian Last Name		
First Name		
Phone		
Address 1		
Address 2		
City		
State	Zip	
Private Insurance Details		
Private Insurance? *	• Yes / No	
Insurer's Name		
Policy ID #		

Phone	

Other Services Beneficiary Is Receiving (Check all that apply)	
Home Health	☐
PCS	☐
Hospice	☐
CAP/C or CAP/DA	☐
Independent Living Services	☐
Block grant services	☐

Is beneficiary currently in hospital or nursing facility? *	• Yes / No	Anticipated discharge date	
If nursing facility transition, is this beneficiary expected to use Money Follows the Person (MFP) resources?	• Yes / No		
If nursing facility transition, is this beneficiary expected to use the community transition service?	• Yes / No		
Is beneficiary receiving another Medicaid program about to end? *	• CAP/C • Other • No		
Beneficiary has been informed regarding their choice of providers.	• Yes / No		
Specify Agency *			
Is Beneficiary interested in the CAP/DA Choice Option?	• Yes / No		
Beneficiary (legal guardian) has agreed to this request?	• Yes / No		

Beneficiary Conditions and Related Support Needs		
Diagnosis Information		
Diagnosis	**ICD9**	**Primary Dx**

No Diagnosis Present - ☐

Is there an active AIDS diagnosis? *	• Yes / No
If AIDS dx present, current CD4 (T) count?	• 200 or less • 201-349 • 350-499 • 500 or greater
Is there a MH diagnosis?	• Yes / No
Is there a IDD diagnosis?	• Yes / No
Medically Stable? *	• Yes / No
Prognosis	
Hospitalizations (Include current stay if applicable)	
# of Unplanned Hospitalizations in Last Year *	
Total Hospitalizations in Last Year *	

Medications		
Medication Name	**PRN**	**If PRN, freq > every 4 hrs?**
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	
	• Yes / No	

# of Prescription Meds	
# of Meds Requiring Nurse to Administer	
# of Psychiatric/Psychotropic Meds Used for MH Dx	
Requires RN Monitored injections and/or IVs	• Yes / No
Considering all current medications, does beneficiary require medications assistance?	• Yes / No
Sensory/Communication Limitations	
Speech ability/making self-understood (Rarely/never) *	• Yes / No
Hearing (Severe difficulty or none) *	• Yes / No
Vision (Severe difficulty or blind) *	• Yes / No

Orientation and Cognitive Status	
Is Beneficiary Oriented	
- To Time *	• No • Yes-Intermittently • Yes-Continuously
- To Person *	• No • Yes-Intermittently • Yes-Continuously
- To Place *	• No • Yes-Intermittently • Yes-Continuously
Beneficiary has Cognitive Skills for Daily Decision-making *	• No • Yes-Intermittently • Yes-Continuously

Mood (Check all that apply)			
Unrealistic fears	☐	Crying/tearfulness	☐
Sad, pained, worried facial expressions	☐	Negative statements	☐
Persistent anger	☐	Anxious non-health concerns	☐
Elevated mood, euphoric	☐	Expansive	☐
Unpleasant mood in morning	☐	Hallucinations	☐
Excessive irritability	☐		☐

Behavior (Check all that apply)			
Wandering	☐	Verbal expressions of distress	☐
Repetitive verbalizations	☐	Angry outbursts	☐
Repetitive physical movements	☐	Dangerous to self	☐
Self-deprecation	☐	Withdrawal from activities of interest	☐
Insomnia/disturbed sleep patterns	☐	Paranoid ideation	☐
Suicide attempt/ideation	☐		

Interpersonal Functioning (Check all that apply)			
Homicidal	☐	Combative/Hx of Altercations	☐
Dangerous to others	☐	Physically abusive	☐
Verbally abusive	☐	Socially inappropriate behavior	☐
Evictions due to inapprop. behavior	☐	Resists care	☐
Fear of strangers	☐	Illogical comments	☐
Reduced social interaction/isolation	☐		

Cardio-Respiratory Support Needs (Check all that apply)

Suctioning – tracheal	☐	Frequency	• Every hour • Every two hours • Every four hours • Every six hours • Every eight hours	• Every 12 hours • Every 24 hours • Less than once a day • 3-6 times per week • 1-2 times per week	• Less than weekly • PRN • Other
Suctioning - other	☐	Frequency	• Every hour • Every two hours • Every four hours • Every six hours • Every eight hours	• Every 12 hours • Every 24 hours • Less than once a day • 3-6 times per week • 1-2 times per week	• Less than weekly • PRN • Other
Ventilator dependent	☐	Frequency	• Continuous • Continuous during sleep • Every hour • Every two hours • Every four hours	• Every six hours • Every eight hours • Every 12 hours • Every 24 hours • Less than once a day	• 3-6 times per week • 1-2 times per week • Less than weekly • PRN • Other
		Stable?	• Yes / No		
		Vent Type	• Negative pressure • Pressure-cycled • Volume-cycled • Combination pressure and volume cycled • Time cycled		
		Infection free?	• Yes / No		
Pulse oximetry	☐	Frequency	• Continuous • Continuous during sleep • Every hour • Every two hours • Every four hours	• Every six hours • Every eight hours • Every 12 hours • Every 24 hours • Less than once a day	• 3-6 times per week • 1-2 times per week • Less than weekly • PRN • Other
Non-vent tracheostomy	☐	Problems with weaning?		• Yes / No	
Nebulizer care	☐	At least 2 schedule/day & 1 PRN/day?		• Yes / No	
Cardiac monitoring	☐				
Chest physiotherapy	☐				
Apnea monitoring	☐				
CPAP/BiPAP	☐	Help getting device on?		• Yes / No	
Oxygen therapy	☐	Requires rate adjustments?		• Yes / No	
Respiratory assessment	☐	Multiple times/day?		• Yes / No	

Nutrition-Related Support Needs (Check all that apply)

Enteral Feeding/Tube Feeding	☐	Frequency	• Every hour • Every two hours • Every four hours • Every six hours • Every eight hours	• Every 12 hours • Every 24 hours • Less than once a day • 3-6 times per week • 1-2 times per week	• Less than weekly • PRN • Other
% of daily nutrition					
Feeding Tube Type	☐	• DT (duodenal) • GJ tube (Gastrostomy-jejunostomy) • GT (Gastrostomy) • JT (Jejunostomy)		• Low profile GT • NG (nasogastric) • OG (Orogastric) • Other	
Parenteral Nutrition (TPN)	☐				
Soft/Mechanical Soft	☐				
Thickened Diet	☐				
Pureed Diet	☐				
Supplemental formula diet physician prescribed	☐				
Diabetes management (daily)	☐	Insulin use	• Yes / No		
		Sliding Scale	• Yes / No		
Weight management	☐				
Fluid mgmt/force fluids	☐				
Input/output monitoring	☐				
Other nutrition treatment/Diet?	☐	Other, Desc			
Ancillary Therapies Being Received (Check all that apply)					
Physical Therapy	☐	Frequency	• More than once a week • Weekly • Every two weeks • Monthly • Less than monthly		
Physical Therapy Details					
Occupational Therapy	☐	Frequency	• More than once a week • Weekly • Every two weeks • Monthly • Less than monthly		
Occupational Therapy Details					
Speech Therapy	☐	Frequency	• More than once a week • Weekly • Every two weeks • Monthly • Less than monthly		
Speech Therapy Details					

Other	☐	Other, Desc	
Other Therapy Details			

Other Support Needs (Check all that apply)				
Continence Management	Bowel	☐		
	Bladder	☐		
Indwelling Catheter	• Yes / No			
Seizure management		☐		
Dialysis		☐	Dialysis Type	• Hemodialysis • Peritoneal • Hemofiltration • Hemodiafiltation • Intestinal dialysis
			Dialysis Frequency	• Once a week • Twice per week • Three times per week • Four times per week • Five times per week • More than five times per week
Wound Care		☐	Open Wound?	• Yes / No
			Sterile Dressing	• Yes / No
Ulcer Care		☐	Ulcer Staging	• Normal • Category/Stage One • Category/Stage Two • Category/Stage Three • Category/Stage Four • Unstageable • Suspected Deep Tissue Injury
Isolation - infection/disease		☐		

Functional Limitations (Check all that apply)	
ADL Limitations with 2 or more ADLs (Hands on assistance this is extensive maximal or total) *	☐
Contractures	☐
Paralyzed	☐
Fall risk	☐
Additional Comments about Treatment Needs	
Additional Comments	

Informal Caregiver Availability				
First Name	**Last Name**	**Relationship****	**Lives with Beneficiary**	**Contact Phone**
			• Yes / No	
			• Yes / No	
			• Yes / No	
			• Yes / No	
**** Relationship –** *Mother, Father, Sister, Brother, Grandmother, Grandfather, Spouse, Other relative, Friend, Professional, Other, Son, Daughter, Husband, Wife, Daughter-In-Law, Sister-In-Law, Niece, Nephew, Granddaughter, Unknown*				
Will 24-hour caregiver availability be required to ensure beneficiary safety? *****				• Yes / No

Beneficiary Consent	
The beneficiary has consented to sharing the information documented in this Service Request Form with any agency or organization responsible for enrolling or assisting the beneficiary once enrolled in the requested service or program(s). *****	• Yes / No

Submitting Agency	
Submitter Name	
CM Agency	
Other Agency Name	
Address	
City	
State	Zip
Phone	
Fax	
Beneficiary's Primary Care Physician	
Primary Care Physician Telephone	

Comments